STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING _____ B. WING _____	C 04/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	**118 MEDICAL DR CARMEL, IN 46032**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00126469 and IN00126781. Complaint IN00126469 - Unsubstantiated, due to lack of evidence. Complaint IN00126781 - Substantiated. No deficiencies related to the allegations are cited. Survey date: April 5, 2013 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 Survey Team: Mary Jane G. Fischer RN Census Bed Type: SNF: 23 SNF/NF: 117 Total: 140 Census Payor Type: Medicare: 25 Medicaid: 101 Other: 14 Total: 140 Sample: 5 Supplemental sample: 3 Carmel Health & Living Community was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the investigation of Complaints IN00126469 and IN00126781.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality Review 04/08/13 by Lisa McColly	F 000		